



ISSN: 2230-9926

Available online at <http://www.journalijdr.com>

# IJDR

**International Journal of  
DEVELOPMENT RESEARCH**

*International Journal of Development Research*  
Vol. 5, Issue, 06, pp. 4693-4697, June, 2015

## Full Length Research Article

### NOSOCOMIAL INFECTIONS IN NEONATAL INTENSIVE CARE UNIT, A PROSPECTIVE STUDY IN A TERTIARY CARE HOSPITAL IN KASHMIR

**\*Imran Gattoo, Asif Aziz, Mohmad Latief and Bilal Ahmad Najar**

Department of Pediatrics, Government Medical College Srinagar, J&K India

#### ARTICLE INFO

##### Article History:

Received 11<sup>th</sup> March, 2015  
Received in revised form  
15<sup>th</sup> April, 2015  
Accepted 24<sup>th</sup> May, 2015  
Published online 28<sup>th</sup> June, 2015

##### Key words:

Neonatal intensive care unit (NICU);  
Nosocomial;  
Infections.

#### ABSTRACT

**Background:** Nosocomial infections are an important cause of mortality in neonatal intensive care units (NICUs). Therefore, in this study, the incidence and prevalence of nosocomial infections were determined in NICUs of a tertiary care hospital in Kashmir, and the causative bacteria were identified in order to provide potential solutions to control the infections in these hospitals.

**Materials and Methods:** This is a descriptive-prospective study in which the cases of nosocomial infections were examined in Nicu of our hospital, which is a tertiary care Pediatric hospital, during 1 year (from June 2013 until May 2014) based on clinical findings, medical and nursing reports of patients, and laboratory results.

**Results:** Of the 3100 patients hospitalized in NICUs of our hospitals, 302 patients were diagnosed with nosocomial infections. The incidence rate of nosocomial infections was 9.74% with 52.4% bacteremia, 32.69% pneumonia, 5.77% urinary tract infections, 5.29% wound infections, and 3.85% necrotizing enterocolitis. There was a statistically significant relationship between invasive procedures (such as umbilical catheters, central venous catheters, surgery, and TPN) and sepsis ( $P = 0.001$ ). The relationships between urinary tract infection and urinary catheter ( $P = 0.000$ ), and aggressive procedures (such as suctioning and intubation) and pneumonia ( $P = 0.001$ ) were also statistically significant.

**Conclusion:** Incidence of nosocomial infections in premature and low birth weight newborns is considered as a health threat. The findings of this research reiterate the importance of giving further attention to prevention and control of nosocomial infections in the NICU.

Copyright © 2015 Imran Gattoo et al. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

#### INTRODUCTION

Nosocomial infections are a major problem for hospitalized patients due to increasing duration of hospitalization and costs of treatment (Sohn *et al.*, 2001). These infections make the treatment of patients difficult due to increasing mortality and morbidity particularly in neonatal intensive care units (NICUs) (Digiovine *et al.*, 1999 and Nagata *et al.*, 2002). Nosocomial infections may involve any organ; however, blood, urinary tract, surgical wounds, and the lower respiratory tract are more frequently involved as compared with other organs. Various factors such as prematurity, low weight, prolonged hospitalization, use of broad-spectrum antibiotics, and particularly the use of invasive procedures such as intubation, ventricular shunt, intra-vascular catheter, and parenteral

nutrition with fat emulsions facilitate the development of such infections, and increase their incidence (Zaidi *et al.*, 2005; Kawagoe *et al.*, 201 and Drews *et al.*, 1995). Prevention and control of nosocomial infections in NICUs will not be possible without identifying the current status of these infections and their predisposing factors. There are numerous reports from around the world, and also from each individual country's hospitals, on the status of these infections (Kadivar *et al.*, 2002). An effective strategy should be implemented in every hospital to prevent nosocomial infection. This strategy should comprise of the following items: continuous care and monitoring of the infection and type of the organism, emphasis on careful hand washing, minimal use of central veins catheters, treatment of people carrying the disease, wise and prudent use of antimicrobial drugs, (Hudome and Fisher, 2001) arranging training programs and providing feedback to staff, and adequate nursing (Adams-Chapman and Stoll, 2002). Therefore, to identify the current status of nosocomial infections, this study examined the incidence and prevalence

**\*Corresponding author: Imran Gattoo**

Department of Pediatrics, Government Medical College Srinagar,  
J&K India

of these infections in NICUs of a tertiary care Hospital in Kashmir, and also identified the causative bacterial agents, in order to provide potential solutions to control the infections in this hospitals.

**MATERIALS AND METHODS**

This is a descriptive-prospective study in which nosocomial infections were studied in a tertiary care pediatric hospital in Kashmir, Northern India during 1 year (from June 2012 to May 2013). Screening forms were completed for all newborns that were admitted in the NICU for 48 hours or longer, based on standard definitions for raised nosocomial infections. Screening forms were composed of four main parts:

- 1) Nosocomial infection is defined as a limited or diffuse infection following hospitalization, which is caused by infectious agents or toxic reactions, and the infection lasts for at least 48 hours after admission till the patient is discharged. Based on NNIS system definitions, nosocomial infections were divided into five groups, including bloodstream infections (BSI), pneumonia, urinary tract infections, surgery wound infections, and necrotizing enterocolitis.
- 2) Information about demographic data of neonate
- 3) Information about the patient’s daily reports in the unit including any changes in vital signs, especially fever during hospitalization; underlying diseases and their severity; location of infection, nosocomial infection signs, timeframe for onset of infection after birth; types of manipulations performed on the infant during hospitalization, including catheterization, surgery, intubation, etc; and information about starting antibiotic treatments in the ward.
- 4) Information about laboratory findings including the type of isolated bacteria, antibiogram, date and place of sampling, and other experimental and paraclinical tests.

Standard and similar methods were used for the analysis and culture of specimens in the three hospitals. All personnel were trained for performing blood cultures and sending them from other parts. The same protocols were implemented in the three hospitals. The supernatant was removed and the sediment was cultured on 5% sheep blood agar and chocolate agar plates using standard techniques and also used for Gram staining. All isolates were identified on the basis of their colony, morphology, culture characteristics, and their biochemical reactions according to standard procedures without culture for anaerobes. In order to prevent between contamination and true positive cultures, in the absence of clinical symptoms and laboratory findings conformity, samples culture was repeated. All isolates were examined for resistance to routine antimicrobial agents by standard disk diffusion method using *Staphylococcus aureus* (ATCC 25923) and *Escherichia coli* (ATCC 25922) as control strains (Clinical and Laboratory Standards Institute, 2007). The antibiotics tested were gentamicin, amikacin, ceftazidime, ceftizoxime, cefotaxime, ceftriaxone, imipenem, ciprofloxacin, co-trimoxazole, chloramphenicol, penicillin, oxacillin, ampicillin, vancomycin, rifampicin and erythromycin (Mast Co, UK). The infection control team examined any clinical signs and all infection sites

on a daily basis, and took culture samples by sterile aspiration from endotracheal tube discharges at the beginning of intubation, and also every week or whenever there were signs of suspected pneumonia. In cases of vascular catheters, culture samples were taken from blood and the catheter if suspected symptoms of sepsis were present. All infants until 48 hours after discharge, premature infants until completion of 44 weeks of gestational age, and in surgical cases 30 days post-operation with over 48 days after their admittance in the NICU were checked for nosocomial infections. After the infection was confirmed, detailed information of nosocomial infection cases was recorded and the prevalence and incidence of nosocomial infection in the NICU were identified monthly. Nosocomial infections were divided into five groups, including BSI, pneumonia, urinary tract infections, surgical wound infections, and necrotizing enterocolitis. According to control practitioner and standard definitions, if the neonatal nosocomial infection did not fall under any of these five groups, it was excluded from the study. This study was conducted with parental consent and ethics committee approval. Data were analyzed using SPSS software version 13 and  $P < 0.05$  was considered to be statistically significant.

**RESULTS**

During the study period, from a total of 3100 patients hospitalized in NICUs of the three hospitals, 302 patients were diagnosed with nosocomial infections. The incidence rate of nosocomial infections was 9.74%. Of the 302 affected newborns, 178 patients (58.90%) were males and 124 patients (41.1%) were females. 78 patients (25.8%) were delivered vaginally and 224 patients (74.2%) were born by cesarean section. Birth weight distribution was as follows: 30 patients (9.93%) were less than 1000 g, 75 patients (24.83%) were 1000–1500 g, 76 patients (25.16%) were 1501–2500 g, and 121 patients (40.06%) were over 2500 g. Minimum and maximum gestational ages were 25 and 40 weeks, respectively with an average of  $34.6 \pm 4.81$  weeks. The lowest and the highest age of the newborns at the time of admission were one day and 40 days, respectively, with an average of  $9.5 \pm 5.8$  days. 210 patients (69.53%) were discharged, and 92 patients (30.46%) had died (Table 1).

**Table 1. Demographic data of neonate with nosocomial infections**

Demographic data	
All	n=302
Gender	Male : n=178 (58.9%) Female : n=124 (41.4%)
Out Come	Discharge n=210 (69.53%) Death: n=92 (30.46%)
Age	Min : 1 day Max: 40 days Mean: $9.5 \pm 5.8$ day
Birth weight	1000-1500 g: n=75 (24.83%) 1501-2500g : n=76 (25.16%) >2500 g n=121 (40.06%)
Reproductive age	< 25 w >40 W Mean: $34.6 \pm 4.81$
Delivery Type	Cesarian : n=224 (74.2%) NVD : n=78(25.8%)

Among the study patients, 100 patients (33.11%) had urinary catheters, 264 patients (87.41%) were intubated, 96 patients (31.78%) had umbilical catheters, 220 patients (72.84%)

received parenteral alimentation, and 34 patients (11.25%) underwent surgery. Bacteremia, pneumonia, urinary tract infections, wound infections, and necrotizing enterocolitis were observed in 52.04%, 32.69%, 5.76%, 5.28%, and 3.84% of the patients, respectively (Table 2). There was a statistically significant relationship between the invasive procedures (such as umbilical catheter, central venous catheter, surgery, and TPN) and sepsis ( $P = 0.001$ ). Also, there was a significant relationship between urinary tract infection and urinary catheter ( $P = 0.000$ ), and between invasive procedures (such as suctioning and intubation) and pneumonia ( $P = 0.001$ ).

**Table 2. Frequency of microorganisms isolated from neonates with nosocomial infections**

Microorganisms	Frequency	percent
<i>Coagulase-negative Staphylococcus</i>	62	<b>20.52</b>
<i>klebsiella</i>	54	<b>17.88</b>
<i>Candida</i>	16	<b>5.2</b>
<i>Staphylococcus aureus</i>	6	<b>1.9</b>
<i>E. coli</i>	5	<b>1.6</b>
<i>S. Viridans</i>	3	<b>0.9</b>
<i>Gram-negative bacilli</i>	3	<b>0.9</b>
<i>Enterobacter</i>	3	<b>0.9</b>
<b>Frequency of microorganisms isolated in infants with urinary tract infection</b>		
<i>Candida</i>	11	<b>3.6</b>
<i>E. coli</i>	5	<b>1.6</b>
<i>Gram-negative bacilli</i>	5	<b>1.6</b>
<i>klebsiella</i>	4	<b>1.3</b>
<b>Frequency of microorganisms isolated in infants infected with pneumonia</b>		
<i>psudomonas</i>	18	<b>5.9</b>
<i>klebsiella</i>	16	<b>5.2</b>
<i>Acinetobacter</i>	30	<b>9.9</b>
<i>E. coli</i>	8	<b>2.6</b>
<i>Candida</i>	5	<b>1.6</b>
<i>Serratia</i>	2	<b>0.6</b>
<i>Gram-negative bacilli</i>	2	<b>0.6</b>
<b>Frequency of microorganisms isolated from neonates with surgical wound infection</b>		
<i>Enterobacter</i>	2	<b>0.6</b>
<i>klebsiella</i>	2	<b>0.6</b>

non-fermentative gram-negative bacilli. Organisms isolated from cultures of endotracheal secretions were 30 cases (9.9%) of *Acinetobacter*, 16 cases (5.29%) of *Klebsiella*, and 18 cases (5.9%) of *Pseudomonas*. The highest antibiotic resistance was seen against erythromycin, oxacillin, clindamycin, and gentamicin in gram-positive bacteria, and against gentamicin, cephalexin, ceftazidime, ceftriaxone, ceftizoxime, cefotaxime, and cefixime in gram-negative bacteria. The most effective antibiotics were imipenem, ciprofloxacin, and vancomycin for gram-positive bacteria, and imipenem, ciprofloxacin, and chloramphenicol for gram-negative bacteria (Table 4).

## DISCUSSION

This study attempted to determine the incidence of nosocomial infections in NICUs of hospitals to identify their underlying causes, and provide guidelines for prevention of nosocomial infections within these hospitals. In this study, we found that the incidence of nosocomial infections in our NICU was 9.74%. According to various studies, (Payman Salamati *et al.*, 2006) the incidence of infection varies based on birth weight, underlying diseases, medical facilities, and mode of care in different centers. According to reports from other parts of the world, the incidence of nosocomial infections differs within different regions. In the United States, the incidence of nosocomial infections in NICUs was 12%–26.5% based on patients' status (Gaynes *et al.*, 1996). Studies conducted in NICUs in Europe have shown that 11.4% of patients were affected by one of the nosocomial infections, which included septicemia (bloodstream infections) (6/52%), lower respiratory tract infections (12.9%), ear, nose, and throat infections (8.6%), and urinary tract infections (8.6%), respectively (Baltimore, 1998 and Ferguson and Gill, 1996). In general, the incidence of nosocomial infections depends on various factors, particularly characteristics of admitted patients such as prematurity, premature rupture of membrane, respiratory distress syndrome, respiratory failure, convulsions, cyanosis, and underlying diseases in mothers such as malnutrition.

**Table 4. Antibiotic susceptibility of bacteria isolated from the endotracheal tube**

Antibiotics	Ecoli		Acinetobacter		klebsiella		pseudomonas	
	S	R	S	R	S	R	S	R
Amikacin	2 (40%)	3 (60%)	13 (65%)	7 (35%)	2 (16.7%)	10 (83.3%)	8 (72.2%)	2 (18.2%)
Imipenem	0	5 (100%)	1 (5%)	16 (80%)	8 (66.7%)	4 (33.3%)	3 (27.3%)	6 (54.5%)
Tobramycin	0	0	0	2 (10%)	0	0	2 (18.2%)	6 (54.5%)
Gentamycin	0	4 (80%)	6 (30%)	14 (70%)	0	12 (100%)	3 (27.3%)	7 (63.6%)
Ceftazidime	0	5 (100%)	0	20 (100%)	0	12 (100%)	1 (9.1%)	9 (81.8%)
Ceftriaxone	0	5 (100%)	0	20 (100%)	0	12 (100%)	1 (9.1%)	9 (81.8%)
Ceftizoxim	0	5 (100%)	0	20 (100%)	0	12 (100%)	0	9 (81.8%)
Cefotaxime	0	4 (80%)	0	20 (100%)	0	12 (100%)	0	10 (90.9%)
Ciprofloxacin	0	5 (100%)	1 (5%)	19 (95%)	7 (58.3%)	5 (41.7%)	4 (36.4%)	7 (63.6%)
Chloramphenicol	5 (100%)	0	1 (10%)	18 (90%)	10 (83.3%)	2 (16.7%)	1 (9.1%)	9 (81.8%)
<i>Trimetoprim-sulfametoxazol</i>	4 (80%)	1 (20%)	1 (5%)	19 (95%)	3 (25%)	9 (75%)	0	9 (81.8%)

Incidences of sepsis and pneumonia in newborns weighing 1000–2500 g were 54.5% and 37.3%, respectively, which was statistically significant ( $P = 0.001$ ). The organisms isolated most commonly from blood cultures of patients were 62 cases (20.52%) of *coagulase-negative staphylococcus*, 54 cases (17.88%) of *Klebsiella pneumoniae*, 16 cases (5.2%) of *Candida*, and 6 cases (1.9%) of *Staphylococcus aureus*. Organisms isolated from urine cultures included 11 cases (3.6%) of *Candida*, 5 cases (1.6%) of *Escherichia coli* and

Additionally, infants who are given intravenous feeding, especially newborns with central venous catheters, are more exposed to circulatory system infections (Kawagoe *et al.*, 2001 and Kim *et al.*, 2000). In this study, nosocomial infections were predominantly found in males. Furthermore, our study revealed a significant association between invasive procedures (such as umbilical catheter, central venous catheter, surgery, and TPN) and sepsis; urinary catheter and urinary tract infection; and invasive procedures (such as suctioning and

intubation) and pneumonia. Therefore, risk factors and invasive procedures are the main causes of neonatal infections. Among the microorganisms isolated from culture samples in our study, the most prevalent germs were *K. pneumoniae*, *coagulase-negative staphylococcus*, *Acinetobacter*, and *Candida*. Also, the most common organism isolated from blood was *coagulase-negative staphylococcus*. However, the most common bacterium causing nosocomial infections in NICUs varies greatly with time and in different parts of the world. For instance, in Pakistan a study showed that the most prevalent bacterium causing nosocomial infection in neonatal ward in 1991 was *Klebsiella*, but this bacterium was much lower in 2003, as reported in another study (Kim *et al.*, 2000; Aurangzeb and Hameed, 2003 and Bhutta *et al.*, 1991). While bacteria such as *Listeria monocytogenes* and *Streptococcus group B* were not reported in our study, these bacteria are listed as important pathogens in other countries except Iran (Lorber, 1997 and Robibaro *et al.*, 1998). It is not clear whether these bacteria are prevalent in our country or they are not detected due to lack of suitable techniques required for their isolation from patients. In several studies on nosocomial infections in NICUs in hospitals, the most common causative bacterium of nosocomial infections was *coagulase-negative staphylococcus* (Galanakis *et al.*, ?).

In the present study, among the commonly isolated germs, *coagulase-negative staphylococcus* and *S. aureus* were resistant to erythromycin, oxacillin, and clindamycin, and were highly sensitive to vancomycin, imipenem, and ciprofloxacin. Ni-Chung Lee *et al.* also reported that *S. aureus* and *coagulase-negative staphylococcus* were 95% resistant to oxacillin (Ni-Chung Lee *et al.*, 2004). Gram-negative bacteria were resistant to third-generation cephalosporins, cotrimoxazole, and amikacin, and were highly sensitive to imipenem, ciprofloxacin, and chloramphenicol, which is consistent with the results of studies conducted in Brazil and Tehran (Mendes *et al.*, 2005 and Feizabadi *et al.*, 2006). The findings of this research show the importance of paying close attention to the control and prevention of nosocomial infections in NICUs, and emphasize on using more stringent methods by the personnel working in this ward, such as good personal hygiene, and more importantly, frequent hand washing, use of sterile gloves, and using aseptic conditions for invasive procedures and wound care.

Incidence of nosocomial infections in wards, and in premature and low-weight neonates is considered to be a major health threat. Therefore, the programs and policies of the hospital-acquired infections care system should include: 1. Observation of hand hygiene principles, using aseptic techniques in invasive procedures, improving physical space, and observation of standard precautions. 2. Usage of human milk and initiation of oral feedings. 3. Reduction of laboratory testing that causes skin damage. 4. Development of a method to differentiate between contaminations and true-positive cultures. 5. Reduction of intubation days and usage of central lines. 6. Encouragement of teamwork to appreciate those responsible for outcomes. Moreover, due to the changing nature of microbial agents and drug sensitivity patterns in different regions, an annual review would be helpful in determining the strains involved in nosocomial infections and

the drug sensitivity patterns in order to facilitate selection of the appropriate antibiotic for experimental treatments.

## Acknowledgements

Authors want to thank the parents and the guardians who consented for the participation of their children in the study.

## REFERENCES

- Sohn, AH., Garrett, DO., Sinkowitz-Cochran, RL. *et al.* 2001. Prevalence of nosocomial infections in neonatal intensive care unit patients: Results from the first national point-prevalence survey. *J Pediatr*; 139:821–827.
- Digiovine, B., Chenoweth, C., Watts, C. and Higgins, M. 1999. The attributable mortality and costs of primary nosocomial bloodstream infections in the intensive care unit. *Am J Respir Crit Care Med*; 160: 976-81.
- Nagata, E., Brito, AS. and Matsuo, T. 2002. Nosocomial infections in a neonatal intensive care unit: incidence and risk factors. *American journal of infection*, 30:26–31.
- Zaidi, AK., Huskins, WC., Thaver, D. *et al.* 2005. Hospital-acquired neonatal infections in developing countries. *Lancet*; 365: 1175-1188.
- Kawagoe, JY., Segre, CA., Pereira, CR., Cardoso, MF., Silva, CV. and Fukushima, JT. 2001. Risk factors for nosocomial infections in critically ill newborns: a 5-year prospective cohort study. *Am J Infect Control*; 29: 109-14.
- Drews, MB., Ludwig, AC., Leititis, JU. and Daschner, FD. 1995. Low birth weight and nosocomial infection of neonates in a neonatal intensive care unit. *J Hosp Infect*; 30: 65-72.
- Kadivar, M., Shahram, R. and Mozayan, KH. M., 2002. A Survey on nosocomial infection in the pediatric & neonatal intensive care unit of the children hospital medical center.; *Iranian J of Infectious Disease and Tropical Medicine*; 7(18);59-66.
- Hudome, SM. and Fisher, MC. 2001. Nosocomial infections in the neonatal intensive care unit. *Curr Opin Infect Dis*; 14(3):303-7.
- Adams-Chapman, I. and Stoll, BJ. 2002. Prevention of nosocomial infections in the neonatal intensive care unit. *Curr Opin Pediatr*; 14(2):157-64.
- Masoumi Asl, H. editor(s). 2011. The National Nosocomial Infections Surveillance in Iran. A 4 years report. *BMC Proceedings*; Bio Med Central Ltd; P243 p.
- Clinical and Laboratory Standards Institute, 2007. Performance Standards for Antimicrobial Susceptibility Testing; Seventeenth Informational Supplement. CLSI document M100-S17. Clinical and Laboratory Standards Institute, 940 West Valley Road, suite 1400, Wayne, Pennsylvania 19087-1898 USA
- Barak, M., Mamishi, S., Siadati, A. *et al.* 2011. Risk Factors and Bacterial Etiologies of Nosocomial Infections in NICU and PICU Wards of Children's Medical Center and Bahrami Hospitals During 2008-2009. *J Ardabil Univ Med Sci.*; 11(2): 113-120. (Full text in persain)
- Payman Salamati, Ali Akbar Rahbarimanesh, Masood Yunesian, *et al.* 2006. Neonatal Nosocomial Infections in Bahrami Children Hospital, *Indian J Pediatr*; 73 (3): 197-200

- Gaynes, RP., Edwards, JR., Jarvis, WR. *et al.* 1996. Nosocomial infections among neonates in high-risk nurseries in the United States. National Nosocomial Infections Surveillance System. *Pediatrics*; 98: 357-61.
- Baltimore, RS. 1998. Neonatal nosocomial infections. *Semin Perinatol*; 22: 25-32.
- Ferguson, JK. and Gill, A. 1996. Risk-stratified nosocomial infection surveillance in a neonatal intensive care unit: report on 24 months of surveillance. *J Paediatr Child Health*; 32: 525-31.
- Kawagoe, JY., Segre, CA., Pereira, CR., Cardoso, MF. *et al.* 2001. Risk factors for nosocomial infections in critically ill newborns: a 5-year prospective cohort study. *Am J Infect Control*; 29: 109-14.
- Kim, SD., McDonald, LC., Jarvis, WR. *et al.* 2000. Determining the significance of coagulase-negative staphylococci isolated from blood cultures at a community hospital: a role for species and strain identification. *Infect Control Hosp Epidemiol*; 21: 213-7.
- Aurangzeb, B. and Hameed, A. 2003. Neonatal sepsis in hospital-born babies: bacterial isolates and antibiotic susceptibility patterns. *J Coll Physicians Surg Pak*; 13: 629-32.
- Bhutta, ZA., Naqvi, SH., Muzaffar, T. and Farooqui, BJ. 1991. Neonatal sepsis in Pakistan. Presentation and pathogens. *Acta Paediatr Scand* 1991; 80: 596-601.
- Lorber B. Listeriosis, 1997. *Clin Infect Dis*, 24: 1-11
- Robibaro, B., Vorbach, H., Weigel, G. *et al.* 1998. Group B streptococcal meningoencephalitis after colonization in a nonpregnant women. *Clin Infect Dis*; 26: 1243-1244.
- Galanakis, E., Krallis, N., Levidiotou, S., Hotoura, E., *et al.* Neonatal bacteraemia: a population-based study. *Scand J Infect Dis* 34: 598-601.
- Ni-Chung Lee, Shu-Hen Chen, Ren-Bin Tang and Be-Tau Hwang, 2004. Neonatal Bacteremia in a Neonatal intensive Care Unit: Analysis of Causative Organisms and Antimicrobial Susceptibility. *J Chin Med Assoc*; 67: 15-20
- Mendes, C., Oplustil, C., Sakagami, E., Turner, P. *et al.* 2005. Antimicrobial susceptibility in intensive care units: MYSTIC Program Brazil 2002. *Braz J Infect Dis*. Feb; 9(1):44-51
- Feizabadi, MM., Etemadi, G., Yadegarinia, D., Rahmati, M. *et al.* 2006. Antibiotic resistance patterns and frequency of extended spectrum b-lactamase producing isolates of *Klebsiella pneumoniae* in Tehran. *Med Sci Monit*; 12(11): BR362-365

\*\*\*\*\*